



Kansas State Board of Pharmacy
800 SW Jackson, Room 1414
Topeka, KS 66612
www.pharmacy.ks.gov
pharmacy@pharmacy.ks.gov

Main: 785-296-4056
Toll Free: 888-RXBOARD
Fax: 785-296-8420

KBOP APPROVAL #
15- _____
_____ hour(s)

APPLICATION FOR EVALUATION OF CONTINUING EDUCATION **INDIVIDUAL REQUEST**

NOTE: All programs to be evaluated must be submitted in their entirety including but not limited to a sample of program announcement and promotional information. Materials must be submitted at least **30 days** in advance of the program. All materials received for evaluation will be retained by the Board and will not be returned.

1. Name and address of individual requesting approval:

Phone Number: _____ Fax Number: _____

E-mail Address: _____

2. Title of program: _____

3. Date of program: _____ 4. Time: _____

4. Program location: _____

5. Name of sponsor: _____

6. Estimated CE contact time: _____

7. Program Objectives _____

8. Type of seminar (i.e. Live, Correspondence, On-line): _____



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CE sponsors must provide a certificate of attendance/completion. You should retain copies of all certificates of attendance/completion for five (5) years. You must also keep a copy of this evaluation form for your records once it has been approved. If you are audited, you will need to provide the certificate of attendance/completion along with this approval.

FOR BOARD USE ONLY:

_____ This program has been evaluated and is approved for _____ hours of CE credit for two (2) years from the date of evaluation.

_____ This program has been evaluated and is denied for CE credit for the following reason(s):

Date of approval/denial: _____